VOL. 17, NO. 4 APRIL-JUNE, 1968

Inventory

A QUARTERLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. DEPARTMENT OF MENTAL HEALTH

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

About the Center . . .

The A.R.C., as it has come to be known, is a 50 bed in-residence treatment facility for problem drinkers. Located at Butner, N. C., a small community approximately 12 miles north of Durham, N. C. off Highway 15, it is operated under the authority of the N. C. Department of Mental Health. The Center provides residence, treatment and workshop facilities for 38 male and 12 female patients.

A.R.C. Treatment Methods . . .

Treatment is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications.

Length of Stay . . .

The basic treatment program is based on a 28-day schedule. The patient may remain for a longer period if, in the opinion of the staff, it will be of further therapeutic benefit to him. No applications for less than 28 days are accepted.

Admission Requirements . . .

1. Admission is entirely on a voluntary basis and a person cannot be accepted on court order or legal commitment. The Center cannot accept persons who have any court hearing or legal action pending which would interfere with or curtail their treatment program.

2. An appointment for admission is obtained by written or telephone application to the Admitting Officer, 406 Central Ave., Butner, N. C. (telephone 919 985-6770 or 985-4420). All appointments are confirmed by mail. They should be made through a physician or other professional person in the prospective patient's community.

3. Patients are expected to be sober on admission, and the Center will not admit a person if intoxication impairs his functioning. The Center does not have nursing or hospital facilities to treat acute intoxication.

4. A written report of a recent physical examination by a licensed physician must be presented upon admission. The patient's physical and mental condition must be good enough to enable him to participate in the treatment program, walk up and down stairs, etc. The Center does not have hospital beds or nursing staff for the treatment of serious physical or mental disorders.

5. A fee of $7.00 per day is charged for the four weeks of treatment. This may be paid by cash or check at the time of admission, or by an agreement signed by the patient at the time of admission — promising to pay the full sum at some time after discharge.

If a person is indigent he may obtain a letter stating this fact from his local county welfare agency, and upon presentation of this letter at the time of admission the request for payment will be deferred.

The Center does not refuse to admit any person because of lack of money, but feels that patients having treatment should take responsibility for the cost of the services if they are able to pay at the time of admission or later.

6. A social history, compiled by a trained social worker in the local welfare or family service agency or other professional organization is required. Arrangements for the history should be made early enough so that it reaches the Center within a week following admission.

Admitting Days . . .

Patients are admitted to the Center five days a week, Monday through Friday, between 9:00 a.m. and 12:00 noon and 1:00 p.m. and 5:00 p.m. by appointments as described above.

N. C. DEPARTMENT OF MENTAL HEALTH

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"With our increasing awareness of alcoholism as a treatable illness, it behooves us to actively seek earlier means of diagnosis in order to avert the serious consequences to the patient and his family which are seen in the later stages of the illness."

EARLY DETECTION OF ALCOHOLISM

BY MICHAEL THOMAS MENNUTI

Reprinted from the *Melwood Farm Newsletter,* this article is condensed from the prize-winning paper of the 1966 contest for Georgetown University medical students sponsored by Melwood Farm, a treatment center for alcoholics in Maryland.

THE occasionally excessive drinker by his disorderly conduct and hazardous driving is one of the major problems of our civil authorities. However, the problem of the alcoholic per se and his chronic illness has attained such proportions that it ranks highly among the leading public health problems facing our medical personnel and the community. Alcoholism means various things to various people and it is consequently as hard to define as it is to detect and treat. It might best be defined as a chronic illness psychic or somatic or psychosomatic, which manifests itself as a disorder of behavior. It is characterized by the repeated drinking of alcoholic beverages to an extent that exceeds customary dietary use or compliance with the social customs of the community, and that interferes with the drinker's health or his social or economic functioning.

The private physician and personnel in the public health field are in the unique position in which they can prevent, detect, and treat this problem.

With our increasing awareness of alcoholism as a treatable illness, it certainly behooves us to actively seek earlier means of diagnosis in order to avert the serious consequences both to the patient and his family which are seen in the later stages of the illness. Most diseases at their onset are difficult to detect and addiction to alcohol is no exception. Patients often minimize any physical or mental problems until they progress so far as to seriously interfere with the functions of daily life, at which time the disease process may have reached grave proportions.

Certainly the alcoholic patient cannot be expected to recognize his disease accurately in its early stages because the disease itself may adversely modify his judgment; the

stigma surrounding alcoholism encourages "denial" on his part and on the part of his family and friends at this stage. It is, therefore, important that the physician and other personnel be trained to recognize the illness before it becomes advanced.

N. H. Rathod suggests three difficulties which have hindered the early diagnosis and treatment of alcoholism and which will have to be overcome if success is to be achieved. Rathod lists these as follows:

First, the moralizing attitude towards alcoholism still prevalent in many responsible quarters encourages driving it underground.

Secondly, the lack of insight and irrational attitudes of the alcoholic make the patient an uncooperative and, at times, an irritatingly unreliable client.

Thirdly, because most of the available information on diagnosis and treatment has been derived from patients whose illness was too advanced to be treated except by a specialist and in a hospital.

We see that certain popular concepts of the alcoholic and alcoholism which have become solidly entrenched in our society must be dispelled. It is not necessarily a disease of "middle age." In fact, there has recently been a trend toward drinking problems occurring in younger individuals. Secondly, alcoholism does not necessarily take years to develop; and thirdly, the popular conception of the alcoholic as the "skid row bum" should be eradicated. Contrary to popular belief, it is estimated that a mere 7% of alcoholics in the United States today would fit the description of the "skid row bum."

Obviously, the greatest amount of evidence to support the diagnosis of "early alcoholism" will necessarily come from a carefully taken history and psychiatric evaluation of the patient. The physical findings may not be as constant or as helpful. A detailed history should be included while taking a history of any illness. It is certainly never too early to suspect alcoholism in a patient who does drink, but an early diagnosis can only be made through probing and exhaustive questioning and critical evaluation of the data obtained.

Ullman postulates that often the investigator can trace alcoholism to the alcoholic's first drink. He has found that an overwhelming number of alcoholics would say that they remember their first drink.

The physician will find that the details surrounding this are usually emotionally charged and often under tension-producing circumstances. It usually means something more to the patient beyond the mere act itself and the experience is often clothed with ambivalence.

A family history of heavy drinking will frequently be of little help as an isolated factor; however, Rathod has found that approximately 50% of alcoholics do show a strong family history of excessive drinking. Most of this is probably related to social custom but it may add weight to other more solid evidence.

Common patterns which the physician will find in the potential problem drinker include those in which he actively seeks out circumstances or social occasions at which he can be assured there will be drinking. If his prior social patterns do not include this he will usually try to alter the situation (e. g. suggesting a change of luncheon restaurant or bringing a bottle to his weekly card party) and if he is unsuccessful may drift into other social groups. The examples show signs of early preoc-

(Continued on page 28)

BY GERALD GLOBETTI

SELECTED ASSOCIATED WITH FACTUAL

The study on which this article is based was supported by Public Health Service Grant MH02115 from the National Institute of Mental Health. The author is Associate Professor of Sociology at Mississippi State University, State College, Miss.

CURRENTLY, there is an abundance of scientific information concerning the nature and the use of ethyl alcohol. Many early ideas about the properties and effects of intoxicants, the consequences of drinking, and the images of the alcoholic are either being discarded or revised while new ones are being developed. Yet, despite the availability of data, the problem of the proper means of disseminating this information to the layman still remains. The objective gathering of facts about alcohol has come about much easier than the unbiased transmission of these facts. Consequently, many misconceptions pertaining to alcohol and its use are still significant components of the public mind.

Unfortunately, studies of the factors which relate to an individual's cognizance of objective facts about intoxicating beverages is an area relatively untouched. Accordingly, the purpose of this paper is to ascertain the existing level of scientific knowledge concerning alcohol found within a representative sample of adults in two Mississippi communities. Two types of data are examined. The first involves the development of an index to measure knowledge about alcohol and its use. The second includes an analysis of the distinguishing characteristics of those individuals who are knowledgeable in this respect, as compared to those who lack knowledge.

The significance of this study is based upon several considerations. First, the guidelines afforded by this paper should lend efficiency to the implementation of an alcohol education program on the local level. Most educators and action workers agree that an initial assessment of the student is a highly desirable, if not a mandatory, prerequisite to effective teaching. The advantages gained thereby are just as applicable to a field task of education as they are to a classroom situation. Second, this research should indicate those subgroups to whom educational devices need to be directed in order to upgrade the level of knowledge about alcohol within the comunity. Finally, several studies have demonstrated that favorability toward alcohol education programs is influenced by adequacy of objective knowledge about alcohol and alcoholism. Subsequently, the highly knowledgeable individual may be employed as a primary stimulator for alcohol instruction in the community.

Source of Data and Sample

The larger study, from which these

SOCIAL FACTORS

"This report reaffirms the position that there is no one program of alcohol education, nor an "alcohol education package," applicable to all subsystems within the community."

KNOWLEDGE ABOUT ALCOHOL

data are taken, is concerned with the activation of a community oriented alcohol education program in two Mississippi localities. The aim in this respect is to demonstrate that it is possible to saturate a community with information about alcohol and alcoholism through a comprehensive effort, utilizing all existing local structures and resources to their maximum potential. In this way it is hoped that an awareness of community needs in these areas as well as a means to meet them will result.

As a part of its preliminary planning, this program was structured to provide an answer to a question of the delineation of the current state of knowledge regarding the subject of alcohol. This study was undertaken with the realization that this factor could facilitate or retard the implementation of the program. Moreover, with such information it is possible to structure the instructional program to deal more effectively with the needs of its potential users.

The ensuing analysis is based upon a universe of household heads or homemakers of residence units included in the 1965 city directories of the communities surveyed. A simple random sample consisting of 452 respondents was taken. Of this number, 327 were contacted by personal visitation and interviewed from a pre-tested schedule consisting of both closed and open-ended questions. The subjects included in the sample but not interviewed were missed for a variety of reasons, for example: non-existent address (3%); not at home after three calls (7%); on vacation (4%); refusals (8%); and, other (6%).

Findings

The dependent variable, knowledge about alcohol, was operationalized by combining a battery of dichotomously scored items into an index. The items are as follows:

(1) A person who drinks regularly keeps setting up an increasing physical craving for more alcohol.

(2) Strong liquor is physically stimulating and thus is good for shock and exposure.

(3) Alcohol requires no digestion. It passes directly into the blood stream and is carried to all parts of the body.

(4) Alcohol is described medically as a depressent.

(5) All things being equal, when two people of different body size (e.g. 130 lbs. and 250 lbs.) drink equal amounts of alcohol, the effects will be the same for both.

(6) The making and consumption of alcoholic beveragse are largely products of our modern civilization.

(7) Food in the stomach slows down the absorption of alcohol and consequently slows down the rate of intoxication.

(8) Feelings of fatigue can be tempo-

rarily reduced by alcohol.

(9) A child born to parents who were intoxicated when the child was conceived is likely to suffer from some physical deformity.

The Guttman Scaling Technique was utilized in the analysis of responses. Five basic steps were employed. First, each correct reply was labeled as a positive endorsement of the item. From this, the proportion of positive responses to each item was determined. Next the items were ordered in a sequence from the least to the greatest proportion of positive endorsements. Then the response pattern of each interviewee to the individual items was ascertained, noting the frequency of perfect scale types. Finally, the non-scale types were fitted into the scale types so that the number of predictive errors would be kept to a minimum.

Of the original nine questions, four failed to satisfy the requirements of the employed scaling technique and were deleted. The remaining items (4, 6, 7, 8, and 9) were combined into the knowledge index. Scale types on this index could range from a low of 0 to a high of 5. Adults receiving a scale type of 0 were those whose response pattern failed to answer any of the questions correctly. Individuals with the maximum scale type gave a correct response to all items.

For analytical purposes, the sample was classified into three knowledge groups. Persons who possessed scale types of 0, 1, and 2 (41% of sample) were labeled as being low in their knowledge about alcohol; while those with scale types of 3 and 4 (40% of sample); and, 5 (19% of sample) were categorized as being average and high in knowledge, respectively.

This dependent variable was studied in the light of three important community dimensions which have relevance to the establishment of an alcohol education program on the local level; namely, demographic factors, organizational structures, and attitudes and communication regarding beverage alcohol, alcoholism, and alcohol education.

Since demographic variables serve as the basis for different sub-group affiliations, it was assumed that their examination would aid in locating those population groups in the community which were more knowledgeable about alcohol. Adequacy of knowledge was found as being characteristic of white males and females, below the age of 35 years, who were college trained and from the upper socio-economic level. Conversely, a low state of knowledge about alcohol was characteristic of non-white adults, older people, the less educated, and those from lower socio-economic groups.

Further findings suggested that active involvement in the formal associational life of the community was related to a high level of factual information about alcohol. Adults who closely identified with their place of residence and engaged in a number of its service activities were well informed about alcohol. On the other hand, those who were restricted in their interaction or weak in their attachment to the community, seemed to be deficient in this respect.

Cognizance of objective data regarding alcohol was also significantly and positively related to an individual's exposure to information about this subject through such channels as books, periodicals, seminars, and so on. Finally, the knowledgeable person possessed both a favorable attitude toward alcohol education programs and the treatment and care of the alcoholic. For

example, he was much less likely than the person with little knowledge about alcohol to view alcoholism as a self-inflicted disorder or to feel that its victims deserved their fate. Consequently, the knowledgeable individual felt that the public had a responsibility concerning the care and rehabilitation of alcoholics, and that the community was obligated to provide some educational type program to teach about alcohol and alcoholism.

Summary and Conclusions

Although caution must be exercised in drawing conclusions from these data, there are several implications which can be noted for the field of alcohol education in general. First, this paper demonstrates that the level of knowledge concerning alcohol will vary according to subgroup affiliation and membership. This suggests something about the content of an instructional program designed to teach about alcohol. It is obvious that those individuals with a degree of sophistication about alcohol would quickly lose interest in instruction that centered on elementary facts about alcohol. The course content must be tailored to meet the needs of its potential users. Consequently, this report reaffirms the position that there is no one program of alcohol education, nor an "alcohol education package" applicable to all subsystems within the community.

Second, this study has delineated at least one common characteristic of those individuals who are deficient in their knowledge about alcohol, namely a lack of interaction with others. Seclusion or a low rate of participation has been identified as being characteristic of non-white community members, older people, the less educated, and those from lower income groups. The individuals who were not well informed about alcohol tended to possess all of theses features. Educational devices need to be directed toward these sub-groups in order to upgrade their knowledge. This however, poses a formidable situation for the action worker since studies indicate that these are the same individuals who are less receptive to an alcohol education program. Along these same lines it is apparent that knowledge regarding alcohol is a function of education and social class position. Changes in approaches to traditional thinking about a subject are likely to find their strongest opposition among the less educated and lower socio-economic groups. Individuals who possessed little factual data on alcohol were characterized by a lack of communication, by a lack of confidence in experts, and by a greater fear of the new and untried. Thus, the findings of this paper may be explained in part by a pattern of lower class conservatism. Moreover the data suggest that those who might gain the most from alcohol education programs are least equipped to participate in them and least inclined to seek them.

Finally, the results of this study show that favorable attitudes toward alcohol education programs and toward the alcoholic and his treatment, accompany a greater knowledge concerning alcohol. This may be broadly interpreted to suggest that the dissemination of general information will be conducive to more favorable attitudes. However, one must be cautious in assuming causality from concomitance. In other words, it is not known whether knowledge leads to more receptive attitudes or if favorable attitudes make one more inclined to gain knowledge.

Teaching Teachers

Please place on your free mailing list for *Inventory* the Public Health Nursing Teacher Preparation Program, School of Public Health, University of North Carolina.

We look forward to receiving copies of this quarterly journal.

Mrs. Arleen Golden
Secretary to P.H.N.T.P.P.
Chapel Hill, N. C.

Hey, Betty

I recently left Dorothea Dix Hospital and started working here at the Georgian Clinic.

My social work supervisor saw the *Manual on Alcoholism for Social Workers* and liked it so much that she wants to use it here. Would you please let me know if several copies can be made available to the Clinic?

Give my regards to everyone at the Department.

Betty Young
Atlanta, Georgia

Alcoholism, Big Problem

Please send me the journal, *Inventory*. As a nurse I find that alcoholism is a very big problem today and wish to be better informed on some ways to help. Thank you.

Mrs. Rita Williams
Durham, N. C.

For the Judge

Hon. John S. Gardner, Judge of the Disitrict Court, has asked that I write and request you to enter his name on your mailing list for *Inventory.*

Your cooperation will be greatly appreciated.

Betty F. Williams
Assistant Clerk
Superior Court of Robeson Co.

Community College

We would like very much for the Sandhills Community College Library to be placed on your mailing list to receive your magazine, *Inventory.*

Lenox G. Cooper, Jr.
Southern Pines

Industrial Program

Your fine publication has come to my attention and I compliment you upon the good work you are doing—both your institution and your state.

I am generating a report which I hope will initiate a program on alcoholism in my company, which is one of the industrial giants. Would you be good enough to send me any literature which will support the need for such a program, plus any descriptions you might have on programs now operating and what progress they are making. My company will look closely at the cold dollar business benefits.

W. G. Calder
Huntsville, Alabama

Liaison Committee

As a member of the liaison committee between Tarrant County Medical Society and the Tarrant County Council on Alcoholism, we would like very much to receive *Inventory* if possible.

Rex J. Howard, M.D.
Fort Worth, Texas

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ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

BY DON MURRAY

THE HOUSEWIFE'S SECRET SICKNESS

Once the housewife's secret sickness is brought into the open it can then be healed successfully.

IN every American town, on almost every green, shaded street, live housewives who are desperately ill but who do not seek the treatments which are available. They remain prisoners in their homes, isolated by their own guilt and hidden by their families' shame. These lonely, terrified women all suffer the same secret sickness: Alcoholism.

The woman alcoholic is rarely seen intoxicated by her neighbors, but she exists just the same. "There are just as many women drunks in the suburbs as men, perhaps even more," says Mrs. Thomas Delaney, founder and director of CHRILL ("chronically ill") Service, and its alcoholism information center in East Orange, New Jersey, which is operated under the auspices of the the Essex County Medical Association.

Her experience is supported by Dr. Marvin Block of Buffalo, New York, chairman of the American Medical Association's committee on alcoholism. Says Doctor Block: "In my own practice, alcoholism is as common among women as among men. And I have found that the same thing is true with other private physicians who treat alcoholic patients."

Statistics on alcoholism in the United States — 80,000,000 drinkers; 5,000,000 male alcoholics; 850,000 female alcoholics—do not yet reflect the facts as they are known by workers in the field, and for good reasons. Such estimates are based on public records, and most women alcoholics remain hidden.

"The stigma of being a woman alcoholic is so great that women with a drinking problem hide it," according to Mrs. Marty Mann, who is founder and head of the National Council on Alcoholism. Most women alcoholics are secret drinkers who

satisfy their compulsion with primitive cunning.

"The neighbors never knew," one recovered alcoholic woman told me, "that my bedroom floor was skid row." The Fairfield County (Connecticut) Council on Alcoholism has estimated that there are nine hidden alcoholics for each one who is known.

The woman drunk is protected by her husband, her parents, her children, her family physician. In a good neighborhood there is a conspiracy of discreet silence. The woman alcoholic is treated for "female troubles" by her family doctor and admitted to the private hospital for "a nervous disorder." Her name does not appear on the police blotter and, when the woman alcoholic dies, there is rarely an auptosy. The cause of death often is listed delicately as "heart failure."

Despite this protective conspiracy, the woman alcoholic is beginning to reveal herself and to seek treatment. I have attended meetings of Alcoholics Anonymous—once a predominantly male organization—where there were as many women as men. The number of women coming for help to the sixty-one alcoholism information centers affiliated with the National Council on Alcoholism is increasing steadily.

The problem of the woman drunk is as old as the grape, and there is no evidence that the percentage of women drinkers who become alcoholics is increasing. What is startling is the fact that today most young women drink in college, in bars on their way home from work, in the suburbs after they are married. The woman who has never had the first drink cannot become an alcoholic. Since World War II the number of women drinkers has multiplied dramatically and so, inevitably, has the number of women who cannot

The woman drunk is protecte

control their drinking.

Take a drive through a pleasant New Jersey suburb with Mrs. Delaney, as I did, and you'll begin to see the dimensions of the problem of alcoholism in women.

"See that house over there, the one with the tricycles out in front?" Mrs. Delaney slowed her car, and I saw a very pleasant split-level, a home whose neatness was marred only by the delightful evidence of children—tricycles, a sandbox, a swing, an abandoned doll.

"She has five children, and she's been sober five months this time," Mrs. Delaney told me grimly. "She's a lovely girl when she isn't drunk. She was married in her teens, and she was an alcoholic as a teen-ager too. Meet her and you'd like to have her for a neighbor, yet she's been in and out of half a dozen mental institutions and tried about every cure there is. Last time she hit bottom, and she may make it now. Some have to go all the way down before they can start up."

As we drove off, I thought of what a member of the Fairfield County Council on Alcoholism in Connecticut told me. She said, "We have 12,000 alcoholics, but the alcoholics have 60,000 persons in their immediate families. We think they are all involved in the problem of alcoholism."

"This isn't the Bowery, is it?" Mrs. Delaney brought me back to New Jersey and pointed to an English manor house set high on a double lot. "The woman who owns that home is in a hospital now. She's a physical wreck who looks at least twenty years older than her real age, fifty-eight. You'd never think she was a

by her husband, parents, children and her family physician.

lush if you met her. She's a lady—genteel, soft-spoken, gracious."

Mrs. Delaney nodded sadly. "It's an old story. By the time her children grew up and left home, her husband was a success. He traveled a great deal, and she was left alone. She never drank in front of anyone, but she started to drink alone; and after he died, she rarely left the house, didn't even get dressed for weeks. Time turned upside down, until night was day and day was night. She drank until she passed out, got up and drank herself into oblivion again. We never would have found her if she hadn't gone to a doctor for another ailment.

"Why didn't her children do something?" I asked.

"They didn't know," Mrs. Delaney smiled. "Women alcoholics are the most convincing liars in the world. She wrote them about her busy life. When they wanted to visit, she'd tell them she was going to Europe, or something. Only once in a while did she make a heroic effort to dress up and face them."

We drove on until Mrs. Delaney parked in front of a group of expensive garden apartments. "Career women come to us too. They take care of their parents or seek a career in a man's world, sacrificing everything for success, and then something happens. In one of those apartments over there is a young woman with a Ph.D., but she's a drunk.

"She's been in to see us, but she isn't ready for help yet." Mrs. Delaney pulled way from the curb. "Her employees don't know, although they may be wondering why she's sick so many Monday mornings. She's a falling-down drunk, but her booze is delivered, and you never see her on the street. If you met her, you wouldn't suspect it. She's charming, graceful, intelligent—and very sick."

When we arrived at her office, Mrs. Delaney summed up our trip, "People think of the woman drunk as an old hag, a blowzy creature who would never live in a nice neighborhood. They wouldn't believe that people they know are alcoholics, and therefore they won't help them get treatment. That's the trouble. They won't admit alcoholism is a disease and that the woman who has a serious drinking problem could be their next-door neighbor, their best friend, even a member of their own family."

Information from authorities on alcoholism across the country confirms Mrs. Delaney's picture of the woman alcoholic. "The large majority of the women alcoholics I know are best described by the word 'dainty,'" writes Mary C. Clark, executive director of the Monterey Peninsula Council on Alcoholism in Carmel, California. "Their portrait is in pastel tones, the skin delicate, the voice gentle, the manner feminine." Sarah A. Boyd, director of the Berks County Committee on Alcoholism in Reading, Pennsylvania, has found that the average woman alcoholic is of superior intelligence, has a better-than-average income, is usually between thirty-six and fifty years and has two or three children. Mrs. Boyd's experience confirms the National Council on Alcoholism estimate that less than 3 percent of all confirmed alcoholics are derelicts.

Reports from alcoholism information centers in Houston, Honolulu, Cleveland, Detroit, Greensboro, North Carolina, and other cities—as

well as conversations I have had with physicians, psychiatrists and recovered alcoholics — all indicate that the woman alcoholic may be shy or vivacious, young or old, too busy or too idle, married or single, but they all have one thing in common: There is a vacuum in their lonely lives that they desperately try to fill with a bottle.

The woman alcoholic has lost her way in life, and drinking has become a way of living. "Instead of facing reality, they try to change it with a drink," one psychiatrist told me. Mrs. Delaney adds, "They all need a crutch to get through life. They try alcohol, then they find they can't get along without it."

For years alcohol seems an efficient crutch. With a drink in her hand the too-busy mother finds the momentary stimulation to face another chore or a moment of calm in the confusion of children's demands, errands and social obligations. The bored woman finds a warming hour of fulfillment, another hour of fuzzy contentment and, finally, a night of oblivion.

According to studies at the Yale Center of Alcohol Studies in New Haven, Connecticut, and elsewhere, women alcoholics tend to start drinking later in life than men, and then progress faster through the final stages of alcoholism than males. Yet there are usually long years while they are clear-headed drinkers, while they have no hang-overs, while they still drink heavily by choice. But somewhere they cross over the line. They take a drink as a stimulant before a party and another as a sedative afterward. Insidiously the drink becomes all things at all times. Social affairs are planned as an excuse to drink, the five-o'clock cocktail becomes a reward—and a daylong goal. Getting the first drink—and the dozens which inevitably follow—becomes a way of life.

Alcoholism is a progressive disease, with permanent signals for the woman who will allow herself to see them. The National Council on Alcoholism, the members of A.A., physicians and psychiatrists and other experts recognize the same warning signs along the road which leads from the drink which is chosen to the one which cannot be refused.

If a woman has become "a slow cooker," delaying dinner so there will be time for an extra martini, if she insists on mixing the drinks so she can "earn" the dividend, if she needs a drink before going to a party and another after she comes home, if she drinks alone, if she plans social occasions which will give her an excuse to drink, if she "sweetens" her own drinks, if she "needs" a drink to face a crisis, she'd better watch out.

If she blacks out, lies to herself and to others about the number and the strength of drinks she has had, drinks "the hair of the dog" in the morning and hides a reserve supply, then she is in trouble and should seek help immediately. Doctor Block adds some advice of his own: "Pay attention to valid criticism from those in your family who care about you. If they are worried about your drinking, don't pass it off—consider it. They may have something to worry about."

Too often the woman speeds past all danger signs and becomes an alcoholic. Then liquor controls her life, then the next drink is more important than anything else—the care of a child, the love of a man, her health, her home, her reputation, her God. As her thirst begins to rule her life, a woman runs head on into a double standard. Among men, heavy drinking is often taken as a sign of viril-

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There is a growing body of opinion that a more realistic approach to drinking and driving is needed.

BY RONALD G. SHAFER

DRINKING and DRIVING:

RESEARCHERS IMPLICATE ALCOHOLICS IN ACCIDENTS

I thought I had the car under control, but my head was spinning.

Suddenly, at 45 miles an hour, I had to make a quick lane-change to the left. I swerved wild, crashing into a barrel sitting on the edge of the road. The barrel went flying as the car skidded off the roadway.

Why? I was drunk. In the previous three and a half huors, I had consumed the equivalent of 9 to 10 whiskey-and-water highballs. My reflexes and judgment were shot.

Fortunately, my drunk driving wasn't on a crowded highway. It was on a remote corner of General Motors Corp.'s big auto proving ground here (Milford, Mich.). GM provided the car (a red 1968 Pontiac Bonneville) and the whiskey (Jack Daniels—Black Label). A cold-sober test driver, Russ Beadle, was at my side, ready to take over the controls.

I was here to get a behind-the-steering-wheel sample of alcohol's effect on driving. The experience was, well, almost sobering.

On the nation's public roads, the combinaton of alcohol and automobiles is a daily and increasingly deadly mixture. Federal auto-safety authorities are convinced that drinking drivers (and pedestrians) account for more than half of the nation's 50,000 deaths annually. "And in the case of the single-car, run-off-the-highway type of accident, about 75% involve very heavy drinking," says Lowell Bridwell, Federal Highway Administrator.

Defining Drunkenness

Currently, Federal officials are pressing states to stiffen their drunk-driving laws by tightening the legal definitions of drunkenness and forcing suspected drunken drivers to undergo a test of their blood's alcohol content. Within the next few weeks, further recommendations are expected in a drunk-driver report

The author, Ronald G. Shafer, acted as "guinea pig" in the experiments he describes and the results were published in the June 6, 1968 edition of the *Wall Street Journal* for whom he works as a staff reporter. The article in *Inventory* is condensed from the original.

being prepared for Congress by the National Highway Safety Bureau.

Meanwhile, Federal officials say one of their major tasks is to overcome misconceptions about drunk driving. Recent research indicates that most damage is caused by the excessive drinker, or alcoholic, and not by the social drinker driving after one or two drinks. "We've got to get across the message that in most cases, we're after the sick drinker, the driver who really gets smashed," says a spokesman for the Federal safety agency.

Eventually, records of all drivers may be fed into computers at both Federal and state levels to help weed out inveterate drunk drivers and other problem motorists when they apply for a driver's license or renewal. This would entail expansion of the National Driver Register Service, which now has on file the records of more than 1.4 million drivers whose licenses have been revoked for traffic offenses. Last year the service received 12.3 million inquiries from states that check persons applying for licenses. About 180,000 of the drivers on record had been convicted of drunk driving; one man had lost his license 33 times in seven states for driving while intoxicated.

To find out just what happens to a drinking driver, I arranged with GM to take two drunk-driving tests it had set up for its own research. The first required an evasive action —a last-second lane switch to avoid an accident when it's too late to brake to a safe stop. It worked like this:

Driving the Pontiac. I zipped down the middle of a quarter-mile-long roadway at 40 to 50 miles an hour; ahead on either side was an adjacent parallel lane marked off by rows of foot-high orange plastic cones. At 120 to 90 feet from the marked lanes, one of two lights side by side over the center lane flashed red. (I didn't know in advance which light would flash.) I had less than two seconds to react to the red light and wheel the car in that direction—right or left—into the adjacent lane without braking and, if possible, without striking any of the cones.

In addition to the lane-change course, I tried a second course: A 10-foot-wide roadway with three curves and one straightaway, all marked on each side by rows of plastic cones. I had to try to drive the Pontiac through the curved course without hitting anything.

There were four sequences of tests, given at various stages from sobriety to inebriation; in each sequence, I ran both courses eight times. Meanwhile, I downed one half of a fifth of whiskey. A Breathalyzer machine was used to measure the increasing amount of alcohol in my blood.

What About One Drink?

My drunk-driving experience left me with these conclusions (plus one king-sized hangover).

First, a small amount of liquor didn't make me an unsafe driver. In fact, when the alcohol in my blood measured .02% by weight—sober by any scientific standard—my driving reactions actually improved.

(Other tests have yielded similar results. One of the most extensive was a 1963 study of 15,000 drivers in Grand Rapids, Mich., by the Indiana University department of police administration. That study indicated drivers with blood-alcohol levels between .01% and .04%—generally equal to one or two drinks—were less likely to cause accidents than nondrinkers. The researchers don't conclude, however, that it's better to drink and drive—only that moderate drinking, up to .04% to .05% levels,

isn't necessarily inconsistent with safe driving.)

Nonetheless, in my case, alcohol began taking its toll long before I was aware of it. At a blood-alcohol level of .04%, my reaction time on the lane-changing course, as measured by electronic devices in the car, was 33% slower than my time before drinking.

When my final drink put me at .08%, my impairment was obvious. Cones—and barrel obstacles added later—fell like bowling pins as the car weaved unsteadily through the courses. On the curved roadway, I had made 24 runs without hitting anything when my blood-alcohol level was relatively low; at the .08% level, I toppled 40 cones in eight runs.

Finally, my experience indicated that drunkn driving laws in the U. S. are lenient. Despite my obviously impaired driving ability, at the .08% level I would have been legally drunk in only one state—Utah. In most states, the legal limit is .15%; in a few, .10%. (Researchers figure anybody is drunk over the .08% level.) In most states, drivers are presumed sober with a blood-alcohol rating of .05% or less.

Under a Federal safety standard announced last year, states are required to set a blood-alcohol limit of .10% and to have an "implied consent" law that forces suspected drunk drivers to take a blood-alcohol test or give up their licenses. Currently, the limit is .10% or below in only 11 states. Only 29 states have implied-consent laws. And the Federal Government so far hasn't set any deadline for states to meet its standard. Generally, researchers figure it takes a 150-pound man about four normal drinks — 1½ ounces of liquor per drink—in one hour to reach the .10% level.

As in my case, other studies show that drunk-driving usually involves a consumption of liquor far beyond what's considered social drinking. A study of 1,500 traffic deaths in California in 1966 indicated that 8 of 10 fatally injured drinking drivers had a blood-alcohol content of more than .10%. In the majority of deaths, the level was between .15% and .24%—the equivalent of drinking anywhere from six cocktails to more than half a fifth of liquor in an hour's time.

After drinking that much, "the average person literally would be under the table," contends Dr. Julian Waller, a California public health official. He estimates that 6.5% of California's 10 million drivers are problem drinkers, or alcoholics. Such drinkers, he figures, account for two-thirds of the state's highway fatalities involving drinking drivers.

Safety researchers naturally don't absolve the social drinker completely. But they stress that when such a drinker causes a highway death, he's usually a young driver still learning to handle both cars and liquor. "The significant cutoff appears to be the .05% blood-alcohol level," says R. W. Borkenstein, director of Indiana University's department of police administration. Below that point, he figures, most adult drivers can drink and drive safely.

There is a growing body of opinion that a more realistic approach to drinking and driving is needed. "Considering there are 102 million licensed drivers in the U. S. and that 93.5 million persons drink, there must be substantial overlap, says Kemper Insurance Group. On that assumption, Kemper puts out a booklet counseling that "If you drink—don't drive" is still the best advice. "But if you should do both . . . stay within sensible and realistic limits for drinking and driving."

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ALCOHOLISM IN

BY BARBARA HOLMAN

Alcoholism is not easy to understand, but with the aid of modern society and continuous research, it is certain to become a less complicated problem in the future.

Miss Barbara Holman, a senior at Little River High School in Durham County, won a $300 scholarship to the "college of her choice" with this prize-winning essay. The contest, sponsored by the Durham Council on Alcoholism, was open to all seniors of seven city and county high schools. Five scholarships totaling $1,000 were awarded in all. Miss Holman's essay as published here has been condensed from the original.

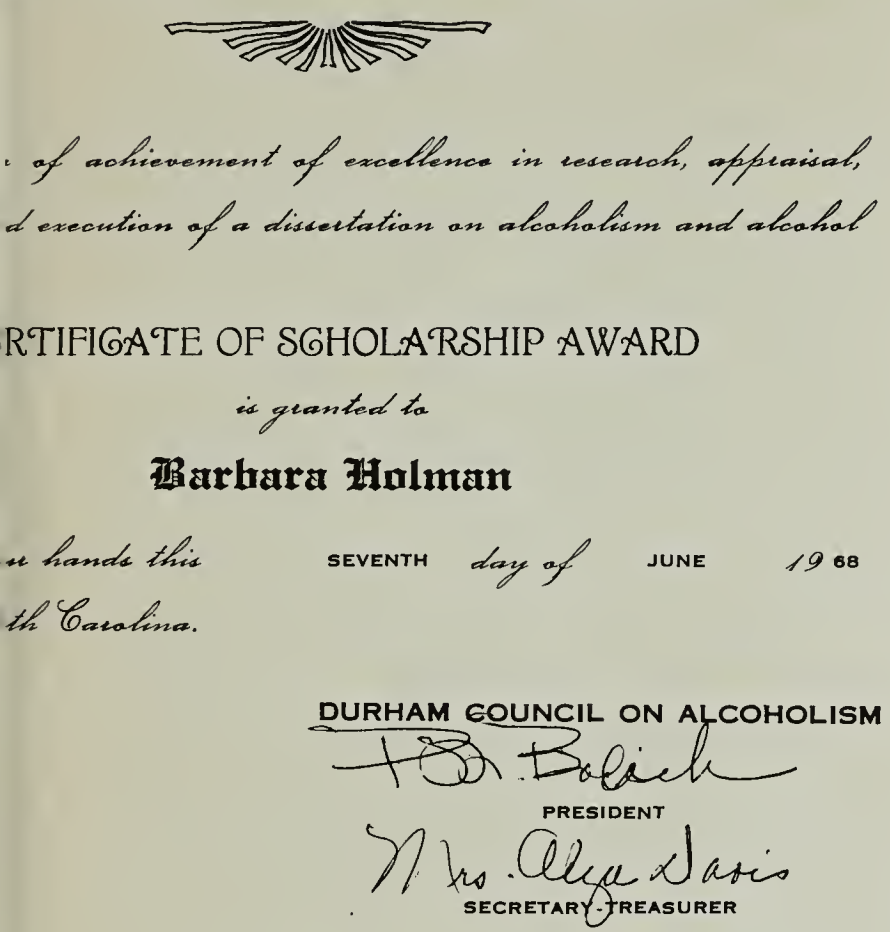
ALCOHOLISM today is widely known and openly discussed. In past years, it was a silent subject. The people of today's modern society are quite concerned with alcoholism and its effects on the alcoholic as well as society. With intensive research being conducted, and a deeper interest in the well-being of the alcoholic, a new flower of modern society has blossomed ready to face the world on its own. Alcoholism has many underlying areas which are now being probed in order to enlighten people on the subject.

Alcoholism has been defined as a sickness resulting in uncontrolled drinking of alcoholic beverages. An alcoholic is a person who cannot control his drinking resulting in problems that affect his family, his job and himself.

Alcohol was not invented by man, he merely discovered it. The earliest cavemen tasted alcohol and experienced its peculiar effects on his appetite and attitude. The Bible mentions drinking in numerous passages, some of which condone the drinking of wine while others condemn its use. "The ancient Egyptians knew how to make beer as well as wine, but distilled alcoholic beverages were probably not known until the Middle Ages."[1]

In today's average American community, it is likely that alcoholic beverages are for sale and in common use. Throughout the country local option — permitting communities to ban the sale of alcoholic beverages within their jurisdiction— is exercised by many localities that do not wish to have bars and liquor stores. However alcoholic beverages are now sold legally somewhere in

1 Norbert L. Kelly, *The New Cornerstones*, Education Division of the N. C. Department of Mental Health, 1967, p. 5.


AM COUNCIL ON ALCOHOLISM

of achievement of excellence in research, appraisal,
d execution of a dissertation on alcoholism and alcohol

RTIFICATE OF SCHOLARSHIP AWARD

is granted to

Barbara Holman

u hands this SEVENTH day of JUNE 19 68
th Carolina.

DURHAM COUNCIL ON ALCOHOLISM

PRESIDENT

SECRETARY-TREASURER

MODERN SOCIETY

all but two states and in the District of Columbia.

"The beginning and form of alcoholic diseases vary widely from person to person. But from scientific evidence so far available, alcoholics may be classed in three main groups or types:

1. The symptomatic alcoholic. This is the person whose chronic drinking is a sign of some underlying mental or physical illness, some defect or inadequacy. This kind of alcoholism is sometimes caused by or accompanied by real mental illness, from a severe neurosis to a psychosis or mental deficiency or psychopathic personality. The alcoholic whose trouble is due to this source needs treatment for this kind of ailment apart from his addiction to alcohol.

2. The true addict. This type of alcoholic is a deeper puzzle. Some scientists think his alcoholism is due to some unusual or abnormal way in which his body reacts to alcohol. This kind of reaction might be inborn, or come during some change during important growth in his life. In any event, alcohol becomes a necessary and quite manageable poison to him or her. As with other alcoholics, he runs into the same kind of physical trouble finally.

3. The secondary addict. Outwardly, this kind of alcoholic may appear to have been a reasonably well-adjusted person for most of his adult life. He starts out as a social drinker but may wind up as an excessive drinker in reaction to some trouble or problem."[4]

Not long ago the public and many doctors, too, had a simple explanation for the sickness of the alcoholic. Alcoholics were merely weak people with no stern will. They really could stop drinking—bingo—like other people if they wished. Or, the answer given was that alcohol was responsible. If alcohol was not available there would be no problem.

The effect which a person attempts to achieve by drinking alcohol is, broadly speaking, *a state of feeling more comfortable*. The real reason for the sickness of alcoholics is whatever is driving them to indulge in *uncontrolled* use of alcohol.

"Many of them have psychological or emotional problems which they cannot solve, or feel unable to solve. They turn to alcohol as a means of escape or 'solution.' For a time, in some cases, it seems to work. There is some evidence that suggests physical causes are also

4 Alton L. Blakeslee, *Alcoholism: A Sickness That Can Be Beaten,* N. Y., The Public Affairs Committee, Inc., 1964, pp. 9-10.

involved at the same time, says Dr. Joseph Hisk, former secretary of the Committee on Problems of Alcoholism, National Research Council. The person who becomes an alcoholic may have some abnormal psychological and physiological reaction to alcohol that social drinkers do not have."[5]

Approximately 94 per cent of the estimated seventy million[6] people in the United States 15 years of age and older who drink alcoholic beverages at some time do not create problems with their drinking. These are the refreshment drinkers, the occasional drinkers and the so-called "social drinkers." They do not use alcohol to the extent that it interferes with their lives in any way. The amount of alcoholic beverages they consume from year to year does not increase beyond the generally accepted limits of moderation.

Excessive, Compulsive Drinkers

In contrast, an estimated six per cent[7] of the people who drink get into difficulties which usually become more serious as time goes on. Generally these people cannot stop drinking, even if they want to, without outside help. They are not only excessive drinkers; they are compulsive drinkers. Alcohol for these people represents the surest means of dulling the pain of living and is their most cherished source of pleasure.

There are numerous symptoms of alcoholism, all of which may be grouped into three basic groups. As described by the Yale Center of Alcohol Studies, they are: 1) pre-alcoholic symptoms—gross drinking behavior, blackout and sneaking drinks; 2) early stages of alcoholism—loss of control, alibi system, drinking alone, changing drinking pattern, anti-social behavior, eye-openers, loss of friends, job and hospitalization; and 3) later stages of alcoholism—benders, tremors or shakes, protecting supply, unreasonable resentments, nameless fears and anxieties, and collapse of alibi system.

"The degree of danger from liquor is not measured in pints or quarts, but in human personality." These are the words of Raymond G. McCarthy, former director of the Yale Summer School of Alcohol Studies, now deceased. They suggest an unhappy truth: the combination of alcohol and immaturity often spells trouble.

How mature a person is *emotionally* by the time he becomes mature *physically* depends very much on the temperament he was born with and the kind of life he has had. His emotional maturity has its roots in his childhood; it stems from all the situations that have molded his ways of thinking and acting, not only in regard to other people and the world at large, but also to himself. The would-be escapist finds the chemical effects of alcohol on the nervous system particularly appealing. The greater the inadequacy, the more need the individual has to hide from himself. This is why honesty with oneself is basic to emotional development and arresting alcoholism.

To grow out of emotional adolescence and reach a state of maturity, a person must do some important learning in four basic areas of living: learning to live with ourselves; learning about work roles; learning to live with others; and learning about sex roles.

It is a fact that anyone who has ever learned about these, cannot do so without at least some frustration, tension, uncertainty and fear of inadequacy. Since these are the very kinds of feelings that lead some peo-

5 Ibid., p. 6

6 Ibid., p. 6

7 Norbert L. Kelly, op. cit., p. 29

ple toward drinking, it is not surprising that the use of alcohol is often associated with these activities.

When drinking is a means of avoiding the sometimes painful process of learning to live with oneself, it is escapist drinking. This is particularly serious for a young person who has a lot of learning to do. It is generally the insecure person who takes refuge in excessive drinking. But like any other means of escape, drinking is unsatisfactory because it prevents doing anything constructive about learning to live with oneself. It also creates new, serious problems.

Emotional maturity shows itself in the ability to form satisfactory relationships with others. It means your life is enriched by your relations with the people around you, whether in the context of school, family, business, church or athletic field. Therefore when things go wrong, when unpleasant situations come up, you are able to adjust to them because you feel secure.

Temporary Effects

Alcohol can relax people, make them feel mellow and close to each other and give them a feeling of belonging. The trouble is that these effects are artificial and temporary; alcohol does not actually help develop these qualities. If a person comes to rely on alcohol in order to cope with social situations, he has not *learned* anything socially or emotionally except to depend on a chemical crutch. The mature person knows his own abilities and limitations. He sets reasonable goals and works to achieve them. The insecure person often sets impossible goals; then no one can blame him for failing.

Alcohol is sometimes a pitfall on the way to making an adjustment to one's work. For some, it eases feelings of insecurity; some rely on it when they feel unable to cope with the fast pace and high pressure of their job. "Alcohol is said to cost industry a billion dollars a year in lost manhours and waste," Dr. McCarthy says, "But to the worker who counts on alcohol to get him through the day, the cost is impossible to measure."

Dating is a key part of growing up in America. It is in this way that young people learn to get along with the opposite sex and eventually choose a partner for life. This delicate task is complicated by the frequency with which the dating picture includes alcohol.

Another detrimental aspect of alcohol is that it is a depressant. The nerve cells have a special sensitivity to alcohol which depresses or alters functions temporarily. Intoxication is due to this special sensitivity to alcohol. Because alcohol does not have to be digested, it goes almost directly into the bloodstream after entering the stomach. Within a minute or two it is being pumped to all parts of the body including the brain where its anesthetic action depresses the brain's three main areas: 1) the upper brain, which controls one's inhibitions, one's feelings about oneself and others and one's judgment; 2) the middle brain, which controls one's muscular activities; and 3) the lower brain which controls breathing, heartbeat and other basic body functions. Alcohol is both eliminated from the body and oxidized, or burned, in the body. Only a small amount is eliminated through the breath, sweat and urine. Most of it is burned in the body as a kind of fuel which creates heat energy. Alcohol is oxidized mainly in the liver at a fairly constant rate.

Alcohol is a food as well as a drug or anesthetic. It is a food because it supplies calories. One-half pint of

alcohol contains as many calories as one-half pound of meat plus one-half pint of milk. The human body cannot store alcohol as it does sugar, so the alcohol is used first to supply energy. Alcohol on top of regular amounts of food can be fattening. It can substitute for food to some extent, for the body is getting calories when you drink. This substitution is a danger for alcoholics, for they get enough calories not to want the foods which supply the vitamins and proteins and minerals that their bodies need for good health.

Many people after years of heavy drinking lose control over the amounts of alcohol they drink. These people frequently develop actual physical diseases as an indirect result of drinking. Most of these diseases are brought about by malnutrition and vitamin deficiencies which result from inadequate nutrition and rest.

"Children of heavy drinkers have mental disorders more often than children of moderate drinkers and abstainers. This could be because the alcoholics had weaknesses in their own genetic make-up, and passed them on to their offspring. But it is also more likely to be due to poor social conditions."[10]

"It is found that children of alcoholics seem more likely to become alcoholics themselves than youngsters from temperate families. This could be because the children from families with a high record of mental disturbances will have a tendency to maladjustments themselves including alcoholism. Children tend to imitate their parents."[11]

"Unless there is broadening of our educational program, greater action, and more understanding of the subject of alcoholism, it is estimated that about six per cent or one out of every 15 teen-agers may become an alcoholic sometime in the future."[12]

Improvement of the home environment, understanding of the factors which contribute to alcoholism, suitable guidance, and proper education can materially modify this estimate. A person's inherent characteristics may play a part in his susceptibility to alcoholism, but these can also be considerably modified by the environment to which young people are exposed and the influences to which they are subjected in growing up.

Parents should learn the early stages of alcoholism and the scientific facts about alcohol and apply them not only to the education of their children, but to themselves as well.

The best way to teach youth is example. If parents conduct themselves in an exemplary way and control their own emotional problems and behavior, the chances of their children having such problems are less. It is important not to expect too much of children. Giving children goals beyond their capacities causes frustration. Participation in clubs and sports helps young people and gives them sufficient interests so many of the aspects of living become challenging and absorbing to them. Young people need the sense of accomplishment that can be achieved in these activities. If such interests can be stimulated, there is less likelihood of their seeking false outlets such as drinking.

There are many underlying symptoms of emotional problems in youth that may lead to alcoholism. Some of the early symptoms are daydreaming, wthdrawal from activity with others, inability to face the ordinary

(Continued on page 31)

10 Alton L. Blakeslee, op. cit., p. 12.

11 Ibid., p. 12

12 *How Teens Set the Stage for Alcoholism,* American Medical Association, 1964, pp. 2-3.

A perilous aspect of modern drug taking is the use of several drugs at the same time.

Drugs and Road Accidents

BY A. A. LARSEN
HEALTH BRANCH, VICTORIA
AND
P. M. RANSFORD
CHAIRMAN
TRAFFIC NAD SAFETY COMMITTEE
B. C. MEDICAL ASSOCIATION

"The Traffic and Safety Committee of the B. C. Medical Association has considered this problem at many of its regular meetings and is taking this opportunity of drawing the problem to the attention of British Columbia physicians. Doctors who receive a request from the Superintendent of Motor-vehicles for information about drugs being prescribed to certain of their patients should realize that the patient in question has usually been involved in a motor-vehicle accident and has tried to excuse himself by claiming that his faculties were impaired because he was taking drugs prescribed by his physician."

DURING 1966, a number of drivers involved in motor-vehicle accidents in this province stated to the police constable investigating the accident that they were taking medication prescribed by their physician and that the drug in question had affected their ability to drive. In most cases no charges were laid under these circumstances, but the Superintendent of Motor-vehicles exercised his right to suspend the license of the driver in question until he produced a report from his physician stating that his patient was no longer taking any medication in doses that might impair his ability to drive safely.

The magazine *Family Safety,* published by the National Safety Council, reports many recent similar incidents in the United States. In Texas a physician became aware of an alarming number of auto accidents befalling his patients for whom he had been prescribing moderate to high doses of a new anxiety-reducing drug. One of his patients smashed his car into a bridge after being "blinded by headlights" and a week later backed his wife's car into a tree. Another hit a telephone pole. A third, who took special pride in his driving, reported that he had "misjudged the distance" and damaged his car badly, ploughing into a parked car. A mother taking this medication totally wrecked a new car, fortunately without major injury to herself or her two small children. An older woman with a long accident-free record collided with another vehicle in city traffic and was outraged when told it was her fault. A man, who had otherwise dramatically benefitted from the drug, collected three speeding tickets in three weeks, backed his new car into a tree and

Reprinted from the British Columbia Medical Journal, Vol. 9, No. 6, June, 1967.

soon afterwards crashed into a parked auto.

Reviewing these reports, the doctor discovered that in a 90-day period, out of 68 patients taking the drug, 10 were involved in minor and six in major accidents, a rate 10 times higher than would have been predicted for the normal population. (Adapted from the Author's "Drugs Cause Crashes" in *Family Safety.)*

A mother had been taking drugs. That is, a few hours before an accident she had swallowed a sedative pill taken exactly as prescribed by her physician. Its side-effects, for which she was totally unprepared, almost caused a tragedy.

In California a woman was homebound from the beach when her station wagon began to weave erratically and jumped the curb. The police who found her unconscious at the wheel discovered a vial of pills which the woman insisted were tranquilizers prescribed by physicians.

According to the *Medical Letter,* dozens of drugs affect the central nervous system in ways that can impair driving ability. The *Medical Letter* noted that a study of drug advertisements in a leading medical journal revealed that more than 50 per cent contain warnings of side-effects which can, and doubtless do, contribute to driving hazards and may be responsible for a significant share of the 50,000 traffic deaths occurring each year in the United States.

Sedatives, tranquilizers, antihistamines and "pep pills" are by no means the only drugs which increase driving hazards by affecting a motorist's muscular co-ordination, nervous reflexes and mental atttude. Many commonly prescribed medications may blur vision, induce attacks of nausea, lightheadedness and changes in blood pressure.

Pain-killing drugs such as intravenous anaesthetics used in tooth-extractions, wear off quickly but some side-effects can linger up to 48 hours. A patient, one physician suggests, might not regain his full reflex activity and be capable of exerting his best judgment for one or two days.

Sleeping pills containing barbiturates induce hypnotic effects for up to 14 hours so that the drug taken the night before may be still at work when one drives to the office in the morning. Similarly, drugs used to combat depression cause such side-effects as temporary confusion, disturbed concentration, blurred vision, drowsiness, dizziness, weakness and incoordination.

One frequently prescribed tranquilizer carries precautions which, if observed, would bar its use by anyone who drives. The manufacturer states "Until the correct maintenance dosage is established, patients receiving this drug should be advised against possible hazardous activities requiring complete mental alertness or physical co-ordination. Driving an automobile during the period of therapy is not recommended." An antibiotic commonly prescribed for kidney and bladder infections may cause drowsiness, visual disturbances, including changes in color perception, difficulty in focussing and double vision.

A perilous aspect of modern drug taking is the use of several drugs at the same time. Unmindful of the risks of mixing their drugs without medical supervision, many people take a tranquilizer in the morning, then during the course of the day they may take antihistamines for a cold, aspirin, cough syrup and then after work a highball or cocktail. Such practices are especially dangerous for motorists because of the mul-

tiple or antagonistic action of these combinations increases the difficulty of predicting the effects.

The most insidious hazard for people who take drugs and drive lies in the escalating or potentiating reaction in the body when an alcoholic beverage collides with a drug with devasting effect. For example, a tranquilizing pill combined with alcohol becomes a sleeping pill. Similarly a sleeping pill of the barbiturate type can, when combined with alcohol, becomes a poison which depresses blood pressure and affects breathing. Results may range from dizziness and black-outs to sudden death. Since the effects vary enormously from person to person, the amount of alcohol or of drugs need not be excessive. Alcohol has been estimated to be a contributing factor in 25 to 50 per cent of fatal traffic accidents. Safety experts are now wondering whether drugs are playing a role in a good number of the deaths attributed to drunken driving. Many law-abiding people who consume alcohol beverages have no intention of drinking to excess or to a degree that would interfere with their driving, yet so many people now take tranquilizers and drink socially that the combination of both must be common. The person who uses alcohol in acceptable social amounts and takes drugs for illness or tension, doesn't realize the danger to his driving that may occur if he doesn't carefully limit his intake.

According to the *Medical Letter,* two of the most commonly used tranquilizers are reported to have, for no known reason, the most serious escalating effect. A person could be drunk because of the inter-action of a single drink and a tranquilizer but a blood test would not reveal it.

The National Safety Council points out that two questions are being raised with increasing frequency and emphasis in the United States:

1. Are doctors doing all they can, and should, to warn their patients that drugs may decrease their driving skill?

2. Are doctors themselves fully aware of how the side-effects of many of the drugs they prescribe can affect driving?

Dr. Richard Walker of the University of Tennessee says that "of major concern is the fact that patients seldom receive warning about the effects medications can have on their driving ability from their physician when he prescribes them. Physicians hesitate to mention these side-effects for fear of causing alarm resulting in the patient not taking the medication."

A pharmacist in a large city sees it differently: "Doctors today carry such a load that they simply don't have time to talk at length to each patient. Many of them now prescribe by telephone. Usually these conversations are brief and brisk. If there is a prescription the doctor may not think to mention driving. Yet if I were to take it on myself to warn the patient when I handed him the prescription, the doctor might get annoyed at me for intruding into his professional business."

A spokesman for the American Medical Association said "When a physician is dealing with an adult, any person over the age of 16, he should be aware that that person is probably a driver. We want doctors to be more mindful of the patient in this regard and to be aware of drugs and possible driving impairment. We are sure that physicians are not taking all precautions in informing patients about the side-effects when prescribing drugs. To resolve this we are in a continuning programme of doctor education."

What's brewing?

A feature designed to help you keep posted on developments in the field of alcoholism.

WASHINGTON, D. C.: Five sponsors and nineteen additional organizations are cooperating in efforts to make the 28th International Congress on Alcohol and Alcoholism to be held September 15-20 at the Shoreham Hotel the best attended in history. The 1968 Congress is the first in the United States in half a century.

The quadrennial meeting is a function of the International Council on Alcohol and Alcoholism of which Reuben Wagnsson of Sweden is president. The USA officers of the 28th Congress include David J. Pittman, chairman; Seldon D. Bacon, chairman of the Program Committee; R. Brinkley Smithers, chairman of the Patronage Committee; L. D. Barney, chairman of the Finance Committee; and A. H. Hewlett, secretary.

The Congress theme is **Alcohol, Society and Man.** Sub-themes have been adopted for each day's plenary session. These are "Status of Research Today," Mon.; "The Problems of Alcohol," Tues.; "Institutional Responses to Problems of Alcohol," Wed.; "Communicating About the Problems of Alcohol," Thurs.; and "Two Unresolved Issues," Fri.

Section meetings organized by topical area or professional disciplines are scheduled on Tuesday, Wednesday and Thursday afternoons. On each day, sections will meet for 70 minute periods with ten meetings being in progress simultaneously. Section meeting topics will be: Biochemical Aspects; Documentation; Education and Youth; Industry and Labor; Law and Drunkenness; Mass Media; Medical Approaches; Non-Medical Therapy; Professional Training; Psychiatric Approaches; Psychology; Public Health and Health Administration; Religion and Church; Social and Cultural Patterns; Traffic Safety; Physiology; and Beverage Controls. Approximately 150 papers will be given throughout the 60 meetings of the 17 sections. Papers have already been submitted from the following countries: Brazil, Belgium, Canada, Chile, Czechoslovakia, Finland, France, Hungary, India, Italy, Japan, Mexico, The Netherlands, New Zealand, Norway, Poland, Romania, Switzerland, Sweden, United Kingdom, United States, U.S.S.R., West Germany and Yugoslavia.

Registration fees are: $30.00 prior to July 1, 1968 and $40.000 after that date. Payment of the full registration fee entitles the individual to receive the published Congress proceedings. It dos not include the banquet on September 19 which will cost $10.00 per person. Attendance at the latter is by reservation. Pre-registration is encouraged and forms are available from the Secretariat Office, 28th International Congress on Alcohol and Alcoholism, Suite 615, 1130 17th St. N. W., Washington, D. C. 20036.

TROUBLE BREWS FOR ALCOHOLICS: In a study of 1,343 persons admitted to California alcoholic treatment centers from 1954 to 1957, and described recently by Rutgers scholar Berthold Brenner, it was found that these alcoholics were: 16 times as likely to die from accidental falls; 30 times as likely to die from accidental poisoning; 3 times as likely to die from other accidents; 3.5 times as likely to commit suicide; 10 times as likely to die from liver cirrhosis; 9.8 times as likely to die of stomach ulcers; 6.2 times as likely to die of influenza and pneumonia; 4.4 times as likely to die of tuberculosis; and 1.8 times as likely to die of heart disease.

ALCOHOL AND HOME ACCIDENTS: Home accidents among persons in their prime working years, 14-64, account for about 8,300 fatalities and more than 8.5 million non-fatal injuries annually. A study of home accidents among Metropolitan Life Insurance Company policyholders indicates that alcohol plays an important role in such accidents among young adults and the middle aged.

The study covered persons aged 15-64 who held Ordinary Life insurance policies and who died in home accidents during 1964 and 1965. It involved 537 male and 310 female fatalities, of which about a seventh of the former and about a fifth of the latter were found to be associated with drinking. The types of home accidents included: acute poisoning by solids and liquids, with frequent involvement of barbiturates; absorption of poisonous gas and vapors, mostly motor vehicle exhausts; falls; fires and other burns among careless smokers; injury by firearms; choking on food; drowning; and freezing.

Above, student recorders give their reports on small group discussions at the final session of the University of North Carolina Summer School of Alcohol Studies June 21. The scene below shows students in class at the alcoholism health education course at East Carolina University which also ended June 21. The summer schools were attended by 95 and 30 students respectively.

CONTINUED FROM PAGE 12

ity, and the phrase, "Drunk as a lord," is a tribute. No one ever said approvingly, "She was drunk as a lady." The woman with an unquenchable thirst must lead a life of unrelenting deception.

One recovered alcoholic told me she used to slither down the side of her bed and crawl to the bathroom to make sure she wouldn't fall and develop revealing bruises. A woman alcoholic will hide a jug in the diaper pail, fill the hot-water bottle with Scotch, stash a fifth in the vacuum cleaner, spike the vinegar bottle. A career woman with perfect eyesight wore spectacles with thick, uncorrected lenses to hide her bloodshot eyes. One woman fooled her husband by keeping gin in the water carafe by her bed; another buried half pints in cereal boxes.

Many women keep changing doctors so one won't catch on to the true nature of their disorders. Mrs. Elizabeth D. Whitney, executive director of the Boston Committee on Alcoholism, has known several women who drank perfume for its alcoholic content, so their breath wouldn't smell of whisky. Vanilla extract has been a staple of women alcoholics for generations, as have many patent medicines with high alcoholic content. Many of these tonics and elixirs are still popular in rural areas and among elderly women.

A woman with a drinking problem develops an extraordinary ability to rationalize. She needs a drink because she is tense, and she needs another to perk her up; she drinks because her husband is away on a business trip, and she drinks to celebrate his return home. Women alcoholics may not always fool others, but they almost always deceive themselves, and that self-deception is the most dangerous of all, for it keeps them from seeking and accepting treatment.

The ability of a woman with a drinking problem to delude herself is astonishing. "I only drink sherry," is a popular, self-righteous refrain that may hide the fact that she drinks half a gallon or more a day. A Connecticut mother, who is now a member of A.A., knew she didn't have a drinking problem because she never touched a drop until the children were in bed. Of course, she kept putting them to bed earlier and earlier in the afternoon and then drinking until she passed out. Another A.A. member told me she convinced herself she was not an alcoholic, because she always hung her clothes up neatly before she blacked out.

Richard Silver, executive director of the Seattle Committee on Alcoholism has found that husbands often encourage such dangerous self-delusion by denying their wives' alcoholism. False pride prevents many a man from admitting his wife could be an alcoholic. Worse still, he prevents his wife from facing her problem, the first step in any successful treatment of the alcoholic.

The woman alcoholic has particular difficulties because she is a woman. As a wife and mother her erratic behavior has a devastating effect on her family. Mrs. Delaney has found that the woman alcoholic is usually a perfectionist who swings wildly from one emotional extreme to the other. She cleans the entire house at once, or doesn't wash a single dish. She refuses to allow her husband near her, or smothers him with aggressive affection. She will have no guests in the house and then invites twelve people to a formal dinner. Her son goes uncorrected for major offenses and then has his bike

taken away for a month for trivial misbehavior. One daughter does not have a birthday party, but her sisters and friends are treated to birthday lunch in the private dining room of a fancy restaurant.

The road of the woman alcoholic is not an easy one. A.A. experience has shown that a mother who is a drunk loses the respect of her children earlier than a drinking father does and is less likely to win it back. Husbands are more apt to divorce an alcoholic mate than a woman is. There is a good reason for this. A woman usually has economic reasons to stick with her husband. He is a feeble reed, but he still may be her only support.

Universal Danger Signal

When a woman "blacks out," an experience shared by all alcoholics and a universal danger signal, she suffers a special horror at the thought of what might have happened while she was unconscious. It is biologically and psychologically impossible for a woman to be casual about blackouts. There are promiscuous women drunks, of course, but the infidelities of a woman alcoholic are often more imaginary than real. Much of the scorn heaped on the woman alcoholic implies that she has been sexually uninhibited. Mrs. Mann, of the National Council on Alcoholism, has a blunt answer to that supposition. "Who wants a drunken woman?" she asks. "When men are interested in her, she's only interested in the next drink. When she passes out, she's vulnerable, of course, but it isn't likely anyone will take advantage of her. She's hardly an attractive woman by then, and her virtue is usually quite safe."

According to such authorities as John T. Crane, executive director of the Flint (Michigan) Committee on Alcoholism, the woman alcoholic is likely to be a plateau drinker who keeps herself on an even keel, although she is constantly sodden and awash like a bashed-in dory floating just under the surface of the water. Many experts feel the compulsive woman drinker usually has more serious emotional ills, in addition to her alcoholism, than the male —and, of course, no treatment can be given until she is sober. Her nervous system sometimes triggers heavy drinking in the premenstrual periods, or during the menopause. Mrs. Delaney, who also runs a rest home for alcoholics, finds that women drinkers are likely to suffer extreme physical damage in a short time. She believes that the physical ravages of heavy drinking cut deeper in the female than in the male.

Most alcoholics suffer extreme malnutrition from drinking without eating. Cirrhosis of the liver, the fifth highest killer of men and an increasing disease of women, is not caused by the amount of liquor drunk but by the lack of proper food. Women alcoholics often confuse their loss of appetite with the will to diet, and drink but do not eat—a certain road to physical ruin.

Modern drugs offer a special hazard to the woman. Doctors often casually prescribe barbiturates, bromides and tranquilizers to calm their nerves, ease their female difficulties, cure their insomnia. Mrs. Delaney believes the woman alcoholic is particularly addictive, and Alcoholics Anonymous has issued a special pamphlet on the subject of drugs and the alcoholic. For whatever the physiological facts may be, the person who depends on alcohol to face life is likely to let drugs take control of him too. In some especially tragic cases a woman who has won the struggle to stop drinking is set off on a

binge by a cough syrup liberally laced with alcohol, or she substitutes capsules and pills for the bottle until she finally becomes a drug addict.

With or without the problem of drugs, the woman alcoholic faces a long, lonely struggle, but she can face the future with hope today. Education has already removed the stigma which once kept the victims of tuberculosis and cancer from receiving treatment. Education is changing the public attitude on mental illness. The same process of illuminating truth is removing the dark shadow which falls over the woman alcoholic.

Today the facts about alcoholism can be obtained from the National Council on Alcoholism, 2 East 103rd Street, New York City, or its sixty-eight affiliates which operate sixty-one alcoholism information centers in twenty-seven states and the District of Columbia. There also are tax-supported agencies working with alcoholics in thirty-nine states. The techniques of the Alcoholics Anonymous recovery program have been proved by the lives of more than 250,000 members, and groups can be reached through a great many local telephone books or by writing Box 459, Grand Central Station, New York City. One of the best books of many on alcoholism is MARTY MANN'S NEW PRIMER ON ALCOHOLISM, published by Rinehart and Winston.

When the Boston Committee on Alcoholism was formed sixteen years ago, it was the first of its kind. Now Mrs. Whitney, its founder, can say, "This is what we tell women who come to us today: The stigma of being a woman alcoholic is being removed, and treatment is available for every woman who wants it."

Once the housewives' secret sickness is brought into the open, it then can be healed successfully.

EARLY DETECTION

CONTINUED FROM PAGE 3

cupation with alcohol. Perhaps a good rule of thumb to follow is to observe whether the drinker worries more about whether his other activities are going to interfere with his drinking than the drinking with the activities.

One may sometimes conclude that the patient lies about his drinking after having questioned the family; it must be kept in mind that it is often the case that the early alcoholic is not lying but has successfully deluded himself into minimizing this problem.

If there is evidence that the subject is under external pressure to control his alcoholic intake, it would be wise to probe for instances and patterns of solitary drinking or what Jellinek describes as "surreptitious drinking." A major sign of this prodromal stage is what is known among heavy drinkers as the "blackout." These are periods of alcoholic amnesia in which the subject appears to be conscious and cognizant of his actions; however, when he comes out of the blackout he has no recollection of the events which occurred during that period.

In conjunction with "blackouts" in the prodromal stage one should interrogate the patient for changing his earliest drinking patterns (i.e. gulping drinks, sneaking drinks, complete avoidance of non-drinking friends). With the appearance of these signs we have come to a turning point in the progression of the disease characterized by loss of control over the amount he drinks on any occasion and of the control over the number of occasions. We finally see him in the bitter fight to protect himself against the knowledge that he has lost control of his drinking.

GUIDELINES for Establishing Eligibility of the Alcoholic Client in a State Rehabiltation Agency

BY EDWARD F. MAU

The alcoholic client is sometimes frustrating to work with, but more often his work potential and high degree of motivation make counseling with him an inspiring experience.

The author, Edward F. Mau, is a rehabilitation counselor with the Bureau of Vocational Rehabilitation of the Commonwealth of Pennsylvania. Pennsylvania has a forward looking alcoholism education and treatment program for state employees in which vocational rehabilitation services play a prominent role.

THE suggested procedure to establish conditions of eligibility for a client on the basis of alcoholism as the primary disability hardly differs from that of any other disability. That is, there must be a responsible expectation that the client can be rendered fit to engage in a remunerative occupation. It must also be clearly shown that this disease generates within the alchoholic specific functional limitations which create a substantial handicap to employment.

One difference that must be pointed out, however, is that the alcoholic must be ready to admit that his compulsive drinking is causing a problem, and that he needs help. **This is crucial.** And this is because of the insidious and invisible nature of the disease of alcoholism. If this admission of a drinking problem is not made with obvious sincerity, the condition is presumed to be active, unstable and recurrent. He is, therefore, not medically acceptable nor actually ready for help at this point.

The least complicated of our alcoholic clients is the one who is still holding down his job, albeit by a slender thread, and has not yet been ousted by his family. He has been threatened several times with the loss of his job. His wife has finally stopped her nagging and is making plans to set up a separate household. If he surrenders and asks for help at this time, his rehabilitation is quite simple. Alcoholic counseling, coupled with an ample dose of vitamin therapy, may suffice to help him retain his job

and reassume his role as head of the family.

The next most eligible alcoholic is the man (or woman) who may have been just fired from a job and is now barely tolerated in his own home as an unwanted guest. This client has a high potential for rehabilitation as he is still a member of the labor force. He can be helped with counseling, therapy, and a personal adjustment training program. The latter is designed to help him gain meaningful insight into the disease concept of alcoholism, and his own true relation thereto.

If the above mentioned alcoholics are suffering the cruel torments of acute alcoholism at the time of initial contact, it is most humane to provide a five-day drying out period. This could help prevent the physical and mental damage caused by convulsions and delirium tremens.

A third eligible alcoholic is the "loner" and job-drifter. He has not yet accepted the skid-row way of life, but may have begun to frequent the row to reduce the pressure of competitively normal living. Because of his long-term separation from his family, he is afflicted with the lonesomeness that induces him to drink for companionship. He seeks out companions of lower and lower community status, ultimately becoming psychologically dependent upon alcohol. His work record is becoming spotty as he suffers lowered tolerance for job frustrations. This unfortunate may have never had any opportunity to know of sources of help, such as family agencies, Alcoholics Anonymous, and vocational counseling and guidance. In his earlier years, this man's work record would reflect some fair degree of stability. Now, with a personal adjustment training program helping him to obtain insight into his problem, job counseling, planned follow-up in Alcoholics Anonymous, and psychotherapy if indicated, there should, indeed, exist a reasonable expectation that this client could be returnned to productive employment. Of the services mentioned, follow-up to insure sobriety would be most important.

A final class of alcoholic who can perhaps optimally use the services of vocational rehabilitation, is the recovering alcoholic who may have as little as six months or as much as five years of total abstinence. While giving the appearance of normal functioning, he may be suffering from the same underlying problem that precipitated his excessive use of alcohol in the first place. At this time, psychotherapy may help him to cope with that problem so that his sobriety will not be threatened.

MUST BE DRY

It is, of course, absolutely necessary that the alcoholic be dry for a substantial period of time, such as the six-month period indicated above, because it is fairly common knowledge that psychotherapy is wasted on the active alcoholic.

Our reference to the eligible alcoholic is intended to include only those designated as the gamma and epsilon types by Dr. E. M. Jellinek. In these two types there is a loss of control over alcohol intake after the first drink. Since this loss of control factor does not occur in the alpha, beta, and delta types, there does not appear to exist medical grounds for acceptance of these types of alcoholics.

The ineligible list extends also to the homeless man, the transient,

the hard core skid-row type, the derelict, and the chronic alcoholic. Other agencies are trying to meet the needs of these people. Eventually, indeed, these unfortunates may become candidates for vocational rehabilitation, following a successful social rehabilitation program.

The active alcoholic may be helped—should be helped if, during a hiatus from his destructive pattern of drinking, he experiences remorse and weariness and asks for help, even though he may not intend to abstain after his physical recovery. In fact, if help is not provided at this point, he may not get another chance. This grim reality recalls four short lines from Wayne E. Oates in "Religious Factors in Mental Illness":

Come, ye weary, heavy-laden,
Lost and ruined by the fall;
If you tarry 'til you're better
You will never come at all.

An interesting phenomenon about the alcoholic population is that 97% is in productive employment. Since our placement activities are thus reduced to a minimum and our services geared to assisting the client **to retain** his employment, it follows that the counselor working with the alcoholic client enjoys a high incidence of successful rehabilitations. The agency, also, derives the benefit of a low cost ratio per client rehabilitated.

Although the alcoholic sometimes proves to be a frustrating client with whom to work, particularly when he returns to drink, his work potential and degree of motivation are so high that, much more often, it is truly an inspiring experience to become involved in a counseling relationship with him.

ALCOHOLISM IN SOCIETY

CONTINUED FROM PAGE 20

problems of life, guilts and anxieties and worries about school and friends or marks and grades, bashfulness, self-consciousness, and other manifestations of inadequacy or inferiority.

There is no magic drug, no magic cure for alcoholism. No pill or injection, not any one single thing that can be done to stop the drinking of an alcoholic and bring recovery. The treatment of the alcoholic is many-sided. The treatment varies with the individual. It depends on why he is an alcoholic, his physical condition, his background, his desire to recover, the availability of help. How long he has been an alcoholic is important and how young or old he is, how well-established his drinking patterns are, and how he is treated by the people who want to help him.

The alcoholic must stop drinking and not use alcohol again. This is his greatest hurdle, probably. To learn to stand alone, when he still wants his crutch and feels helpless at times without it. It is a trying time and the terrible temptation explains many of the false starts and lapses from grace that many times befall the alcoholic in his course of recovery. He must fight this battle of temptation and he can be assisted by understanding, without recrimination, from people who appreciate his problem and are willing to help him gain strength against it. He has the basic job of maturing, of building a new life which he prefers to live without alcohol.

Alcoholism is not easy to understand, even for those who are living close to the problem. But with the aid of modern society and continuous research, alcoholism is certain to become a less complicated problem in the future.

DIRECTORY OF OUTPATIENT FACILITIES BY COUNTY —for ALCOHOLICS and/or THEIR FAMILIES

Key to Facilities

+ Community Alcoholism Program
(supported jointly by the community and the N. C. Department of Mental Health)

*** Community Alcoholism Program**
(supported largely by funds from local boards of alcoholic beverage control)

‡ Joint Mental Health and Alcoholism Facility
(supported by the community and the N. C. Department of Mental Health)

† Mental Health Facility
(supported by the community and the N. C. Department of Mental Health whose services are available to alcoholics and their families)

Competent Help Is Available At The Local Level

ALAMANCE—

+ *Alamance County Council on Alcoholism,* Room 802, N. C. National Bank Bldg., Burlington 27215; Tel: 919-228-7053.

† *Alamance County Mental Health Clinic,* 221 Graham-Hopedale Rd., Burlington 27215, Tel: 919-227-6271.

ALLEGHANY (See Watauga)

ANSON—

† *Anson County Health Department,* Wadesboro 28170, Tel: 704-694-2516.

* *Education Division, Board of Alcohol Control,* 125 Wade St., P. O. Box 29, Wadesboro 28170, Tel: 704-694-2711.

AVERY (See Watauga)

BERTIE (Hertford, Martin)—

+ *Roanoke-Chowan Alcohol Information and Service Center,* 111 Belmont St., P. O. Box 143, Windsor 27983, Tel: 919-794-2895.

BUNCOMBE—

+ *Alcohol Information Center,* Parkway Offices, Asheville 28802, Tel: 704-252-8748.

† *Mental Health Center of Buncombe County,* 415 City Hall, Asheville 28801, Tel: 704-254-2311.

BURKE—

* *Burke County Council on Alcoholism,* 211 N. Sterling St., Morganton 28655; Tel: 704-443-1221.

CARTERET (See Craven)

CABARRUS—

† *Cabarrus County Mental Health Clinic,* 102 Church St., Concord 28025; Tel: 704-786-1181.

CATAWBA—

* *Catawba County Council on Alcoholism,* 420 Seventh Ave., S. W., Hickory 28601; Tel: 704-328-3564.

CLEVELAND—

† *Cleveland County Mental Health Clinic,* 101 Brookhill Rd., Shelby 28150; Tel: 704-482-3801.

CRAVEN (Carteret, Jones, Pamlico)—

‡ *Neuse Mental Health and Alcoholism Center* (Craven County Hospital, New Bern 28560; Tel: 919-638-5173, Ext. 294)

+ *Division on Alcoholism,* 411 Craven St., P. O. Box 1466, New Bern 28560; Tel: 919-637-5719.

+ *Division on Alcoholism,* 506 Broad St., P. O. Box 82, Beaufort 28516; Tel: 919-728-4033.

CUMBERLAND—

† *Cumberland County Mental Health Center*:

+ *Division on Alcoholism,* Cape Fear Valley Hospital, Fayetteville 28302; Tel: 919-484-8123.

DARE (See Pasquotank)

DURHAM—

† *Department of Psychiatry,* Duke University Medical Center, Durham 27706; Tel: 919-684-8111, Ext. 3416.

* *Durham Council on Alcoholism,* 602 Snow Bldg., Durham 27702; Tel: 919-682-5227.

EDGECOMBE (Nash)—

† *Edgecombe-Nash Mental Health Clinic*

+ *Division on Alcoholism,* 228 Hammond St., Rocky Mount 27801; Tel: 919-442-8021.

FORSYTH—

† *Department of Psychiatry, Bowman Gray School of Medicine,* N .C. Baptist Hospital, Winston-Salem 27103; Tel: 919-725-7261.

† *Forsyth County Department of Mental Health*:

+ *Alcoholism Program of Forsyth County,* 802 O'Hanlon Bldg., 105 W. 4th St., Winston-Salem 27101; Tel: 919-725-5359.

† *Forsyth County Mental Health Unit,* 1020 E. 7th St., Winston-Salem 27101; Tel: 919-722-0364.

GASTON—

† *Gaston County Mental Health Clinic,* 318 South St., Gastonia 28052; Tel: 704-864-8381.

GUILFORD—

* *Alcohol Education Center,* P. O. Box 348, Jamestown 27282; Tel: 919-883-2794.

Family Service Agency, 1301 N. Elm St., Greensboro 27401; Tel: 919-273-0523.

Family Service of High Point, 113 Gatewood Ave., High Point 27260; Tel: 919-883-1709 or 919-833-2119.

+ *Greensboro Council on Alcoholism,* 216 W. Market St., 206 Irvin Arcade, Greensboro 27401; Tel: 919-275-6471.

† *Guilford County Mental Health Center,* 300 E. Northwood St., Greensboro 27401; Tel: 919-273-8281.

† *Guilford County Mental Health Center,* 942 Montlieu Ave., High Point 27262; Tel: 919-888-9929.

HENDERSON—

* *Alcohol Information Center,* 2nd floor, City Hall, P. O. Box 472, Hendersonville 28739; Tel: 704-692-8118.

† *Henderson County Mental Health Clinic,* 820 Fleming St., Hendersonville 28739; Tel: 704-692-2138.

HERTFORD (See Bertie)

HOKE (See Moore)

JONES (See Craven)

LEE—

† Mental Health Clinic of Lee County:

+ *Division on Alcoholism,* 106 W. Main St., P. O. Box 2428, Sanford 27330; Tel: 919-755-4129 or 919-755-4130.

MARTIN (See Bertie)

MECKLENBURG—

* *Charlotte Council on Alcoholism,* 1125 E. Morehead St., Charlotte 28204; Tel: 704-375-5521.

† *Mecklenburg County Mental Health Center,* 316 E. Morehead St., Charlotte 28202; Tel: 704-334-2834.

MONTGOMERY (See Moore)

MOORE—

* *Moore County Alcoholism Program,* P. O. Box 1098, Southern Pines 28387; Tel: 919-692-6631.

† *Sandhills Mental Health Center* (Hoke, Moore, Richmond, Montgomery), Medical Center Building, Pinehurst 28374; Tel: 919-295-6851.

NASH (See Edgecombe)

NEW HANOVER—

* *New Hanover County Council on Alcoholism,* 211 N. Second St., P. O. Box 1435, Wilmington 28401; Tel: 919-763-7342.

† *Southeastern Mental Health Center,* 920 S. 17th St., Wilmington 28401; Tel: 919-763-7342.

ORANGE—

† *Alcoholism Clinic of the Psychiatric Out-Patient Service, N. C. Memorial Hospital,* Chapel Hill 27514; Tel: 919-942-4131, Ext. 336.

* *Orange County Council on Alcoholism,* Box 277, Carrboro 27510; Tel: 919-942-1089 or (if no answer) 919-942-1930.

PAMLICO (See Craven)

PASQUOTANK (Camden, Chowan, Dare, Perquimans)—

‡ *Mental Health and Alcoholism Authority:*

+ *Division on Alcoholism,* P. O. Box 645, Medical Bldg., Elizabeth City 27909; Tel: 919-335-1663.

PITT—

† *Coastal Plain Mental Health Center,* 1827 W. Sixth St., Greenville 27834; Tel: 919-752-7151.

+ *Pitt County Alcohol Information and Service Center,* 907 Forbes St., P. O. Box 2371, Greenville 27834; Tel: 919-758-4321.

RICHMOND (See Moore)

ROWAN—

* *Educational Division, Rowan County ABC Board,* P. O. Box 114, Salisbury 28144; Tel: 704-633-1641.

† *Rowan County Mental Health Clinic,* Community Bldg., Main and Council Sts., Salisbury 28144; Tel: 704-633-3616.

SCOTLAND—

† *Scotland County Mental Health Clinic,* 1304 Biggs St., Laurinburg 28352; Tel: 919-276-7360.

VANCE—

† *Vance County Mental Health Clinic,* County Home Rd., Henderson 27536; Tel: 919-492-1176 or 919-438-4813.

* *Vance County Program on Alcoholism,* 158 Bypass W., P. O. Box 1174, Henderson 27536; Tel: 919-438-3274 or 919-483-4702.

WAKE—

† *Mental Health Center of Wake County,* Wake Memorial Hospital, Raleigh 27610; Tel: 919-834-6484.

* *Wake County Health Department,* 3010 New Bern Ave., Raleigh 27610; Tel: 919-833-1655.

WATAUGA (Alleghany, Avery, Wilkes)—

† *New River Mental Health Center:*

+ *Division on Alcoholism,* 210 W. King St., Boone 28607; Tel: 704-264-8759.

+ *Division on Alcoholism,* 101-A W. Main St., Wilkesboro 28697; Tel: 919-838-3551.

WILSON—

Aftercare Clinic, Encas Rural Station, Wilson 27893; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.; Tel: 919-237-2239.

* *Wilson County Council on Alcoholism,* Room 308, 116 S. Goldsboro St., Wilson 27893; Tel: 919-237-0585.

Wilson Mental Health Clinic, Encas Rural Station, Wilson 27893; Tel: 919-237-2239.

WILKES (See Watauga)

EDUCATION AND INFORMATION SERVICES

INVENTORY—quarterly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from the Film Library, N. C. State Board of Health, Raleigh, N. C. Please request films as far in advance as possible and state second and third choices.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—Family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

Library Books—Books on alcoholism are available from the North Carolina State Library through local libraries to residents of North Carolina. To obtain any of the books listed in the March-April, 1964 issue of **Inventory,** go to your community library and make the request.

Staff Speakers—members of the Raleigh and A.R.C. staffs are available for speeches before civic and professional groups.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the Education Division, N. C. Department of Mental Health, Raleigh.

Consultant Service—for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

Education Division, N. C. Department of Mental Health
P. O. Box 9494
Raleigh, N. C. 27603

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